

Bureau Talk

Bureau of Home Care and Rehabilitative Standards

Missouri Department of Health and Senior Services

<http://health.mo.gov/safety/homecare/>



Bureau Welcomes New Staff

Many changes have occurred in the Bureau of Home Care and Rehabilitative Standards since the last *Bureau Talk*. We said good-bye to Gerry Ann Wagner, who retired December 31 after 16 years. As a surveyor, Gerry Ann's primary territory was northwest and west Missouri. We will miss Gerry Ann's expertise, and we appreciate all of her contributions. Please join us in wishing her the best!

On another note, the bureau hired two new surveyors, an office support staff person and has a new section administrator.

Lila Suzanne Hamlet (Suzi) began as a surveyor in September 2011. Suzi has 15 years of nursing experience, has held administrative positions and has experience coordinating and implementing a health care organization's continual survey readiness program. Although Suzi will come into contact with agencies statewide, her primary coverage area is southwestern Missouri.

Deanna McCarter, the second new surveyor, transferred from the department's Section for Long-Term Care Regulation.

For 11 years, she surveyed nursing homes and did complaint investigations in the community. Deanna has also been a home-health and hospice-agency manager. Her primary territory is northwest and western Missouri.

Randi Ray is our new senior office support assistant. Randi transferred from the Missouri Department of Corrections, Division of Adult Institutions. She previously worked for the Missouri Office of Administration, Facilities Management, Design and Construction. Randi is the new voice one hears when calling the bureau. She will process license renewals, maintain the e-mail listserv and agency administrative changes, and perform other duties.

Last but not least, the department's Section for Health Standards and Licensure also has a new face: Bill Koebel. Bill is the temporary section administrator. Previously, Bill managed the enforcement group in the department's Section for Long-Term Care Regulation. Last fall Dean Linneman resigned from the section administrator position.



Bureau Receives Team Award!

The bureau proudly received the Department of Health and Senior Services 2011 Second Quarter Director's Team Award. It also received the Centers for Medicare & Medicaid Services' (CMS) Certificate of Appreciation. The bureau was nominated because it used information effectively to promote the Missouri Department of Health and Senior Services' goals and objectives and CMS' Survey and Certification Program.

CMS and the department recognized the following accomplishments:

- The bureau team continues to meet all the CMS performance standards;
- Bureau surveyors prepared and presented in-services, updated and revised bureau policies, worked on a continuous quality improvement project, and revised the State Home Health Aide Competency Evaluation Test;
- The bureau's office support staff made the bureau more efficient and effective by increasing its use of technology. All bureau records are electronic, paper files are scanned and an electronic Statement of Deficiencies has been developed. In addition, office support staff created an e-mail distribution list to disseminate information quickly and designed a quarterly newsletter. Office support staff also developed a home health branch questionnaire for Region VII. The questionnaire provides a more cohesive and unified systematic approach for approving regional branch offices' home health and hospice applications; and,
- Team member Joyce Rackers, the outcome and assessment information set (OASIS) educational coordinator, helped test the new OASIS-C data set. She created an audit tool to assist bureau surveyors and home-health providers in collecting and understanding that data set.

License Renewals & Agencies' Change of Addresses

1.

Recently surveyors found it very difficult to locate agencies using street addresses only. If your agency is hard to find, please provide detailed directions when submitting a license renewal application.

2.

Some agencies (home health, hospice and OPT) changed locations and failed to notify the bureau. An agency is not allowed to see patients or bill for services from a new location without prior bureau approval. Before the bureau approves a location change, the agency must have its fiscal intermediary submit a copy of an approved 855 to the bureau. The agency will not receive the bureau's approval letter until the 855 is received.

Requests to Expand a Service Territory



The bureau reminds agencies to follow the procedures below when making a request to expand a service territory:

- 1) An agency must submit its intent in writing. It must indicate whether the request is for a county expansion, a branch, a multiple location or an Outpatient Physical Therapy Agency (OPT) extension site.
- 2) The bureau then sends a questionnaire to the agency that needs to be completed within 60 days. If the questionnaire is not completed on time, the agency's request will be withdrawn. However, OPT agencies will receive a bureau packet rather than a questionnaire.

The following criteria must be met before an expansion request can be considered:

For County Expansions:

- 1) The requested counties must be contiguous (touching) counties in an already approved service area.
- 2) An agency cannot expand into another metropolitan or micropolitan statistical area.
- 3) An agency must wait at least one year between requests. Also, if an agency's branch or multiple location has been approved, it must wait one year to request a county expansion.
- 4) An agency must be in compliance with the conditions of participation (CoPs) and state regulations. That is, if an agency has been surveyed and tags were cited, the agency's follow-up survey must be violation-free.

For Branch or Multiple Location Requests:

- 1) A pending branch or multiple location must be located in an agency's already approved service area.
- 2) An agency must wait at least one year between requests. So, if an agency's county expansion is approved, that agency must wait one year to request a branch location or a multiple location.
- 3) An agency must be in compliance with the conditions of participation (CoPs) and state regulations. That is, if an agency has been surveyed and tags were cited, the agency's follow-up survey must be violation-free.

For Extension Sites for Outpatient Physical Therapy Agencies (OPTs)

- 1) An agency must complete an extension site packet and give particular attention to the fire-alarm question. Specific regulatory requirements regarding fire alarms must be met before any extension site can be approved.
- 2) An OPT agency must be in compliance with the conditions of participation (CoPs).
- 3) An OPT agency must have its fiscal intermediary submit an approved 855 to the bureau before the bureau considers the agency's extension site request. Agencies may contact their fiscal intermediaries with questions about the procedure or the time necessary for approval of the 855.

Issues Specific to Home Health



Fee for Service (FFS) HHABN

On Feb. 14, 2012, the Centers for Medicare & Medicaid Services (CMS) posted website changes to Chapter 30, Section 60, of the Medicare Claims Processing Manual. The changes include minor edits to the Home Health Beneficiary Notice of Noncoverage (HHABN) and revised section instructions for form CMS-R-296. The changes are not substantive and do not affect HHABN policy or issuance.

Effective Feb. 3, 2012, the revised section instructions, as published in Change Request 7323, replace the previously published section instructions in the Medicare Claims Processing Manual.

As stated in the instructions at 60.2, Scope of the HHABN, (C) HHABN Issuers and Recipients, “HHAs should contact their Regional Home Health Intermediary (RHHI) if they have questions on the HHABN or related instructions, since RHHIs process home health claims for Original Medicare. Beneficiaries who need assistance may be directed to call 1-800-MEDICARE.”

More FFS HHABN information is on CMS’ website:

http://www.cms.gov/BNI/03_HHABN.asp.

Teleconference

On Nov. 30, 2011, Lisa Coots, Fern Dewert, Cheryl Pappas and Joyce Rackers participated in a Missouri Alliance for Home Care teleconference. The teleconference objectives were to provide home health agencies with a history of the home health survey process; compare the old survey process to the new one; define the different types of surveys; define the top 10 deficiencies for FY 2010 and FY2011 (pre and post the new survey process); provide documentation tips to avoid deficiencies; and, emphasize the importance of OASIS-C accuracy.

For your reference, please find attached Documentation Tips to Avoid Deficiencies (Attachment B).

Occupational Therapy Assistant (OTA) Supervision

The bureau recently spoke with Missouri’s Board of Healing Arts regarding supervision of home health OTAs. Per the board, an OTA has to be supervised by an occupational therapist. The frequency of the supervision, which can be done on-site or by telephone, depends upon an OTA’s experience.

Home Health Aide Competency Evaluation

Revisions to Missouri’s Home Health Aide/Hospice Aide Competency Evaluation became effective on 03/01/12. The evaluation, developed and approved by the Missouri Department of Health and Senior Services’ Bureau of Home Care and Rehabilitative Standards, replaces previously approved evaluations. Missouri home health or hospice agencies that adopt the revised competency evaluation will comply with the Medicare home-health and hospice regulations, and state regulations.

The competency evaluation has two parts: a Written Aide Competency Exam and a Basic Skills Test. Please see Attachment A.

Aides who have successfully passed a previous Missouri evaluation need not be re-tested.

Hospice-Related Issues

Reporting Suspicion of a Crime

An Aug. 12, 2011, CMS Survey and Certification Memo (11-3-NH) states that Section 1150B of the Social Security Act (the Act), as established in the Affordable Care Act, requires specific individuals in applicable long-term care facilities to report any reasonable suspicion of crimes committed against a resident of that facility.



- Reports must be submitted to at least one law enforcement agency and the state agency.
- Reports apply to nursing facilities, skilled nursing facilities and hospices that provide services in long-term care facilities and intermediate care facilities/mental retardation.
- A report of Serious Bodily Injury must occur within two hours of an alleged incident, all other reports within 24 hours.
- Facilities, including hospices, must notify 'covered individuals' annually of their reporting obligations. A 'covered individual' is defined as each individual who is an owner, operator, employee, manager, agent or contractor of a facility.

The Hospice Conditions of Participation (CoPs) differ from 1150B in the following ways:

- The conditions of participation require incident reporting to a hospice administrator. That requirement is in addition to the 1150B reporting requirement.
- The written-agreement requirement with a skilled nursing facility is separate from the 1150B requirement.
- Hospices are cautioned to meet both the 1150B requirement and the pre-existing CoPs.

Hospice Transfers

One question has prompted several calls to the bureau recently: What is required when transferring a hospice patient from one agency to another? The accepting hospice has to do a new admission and meet all the regulatory time frames.

The federal regulations, CFR 418.104(e) L682 Standard: Discharge or transfer of care, state, "(1) If the care of a patient is transferred to another Medicare-/Medicaid-certified facility, the hospice must forward, to the receiving facility, a copy of (i) The hospice discharge summary; and (ii) The patient's clinical record, if requested."

The state regulations, 19 CSR 30-35.010 (D) Discontinuance of Hospice Care, ML 104, state, "(2) If a patient transfers to another provider, including another hospice provider, the hospice transferring care shall provide to the receiving provider pertinent written information which shall include at a minimum: A. Current medication profile, B. Advance directive (if applicable); and C. Problems that require intervention or follow-up."

The agency transferring the patient must provide the accepting hospice with all the documentation outlined in the regulations above in order to be in compliance. *(continued on next page)*



Hospice-Related Issues *(continued)*

Chaplain

An April 2011 *Bureau Talk* article reminded hospices of the state requirements for hospice chaplains. That article contained some confusing information.

To clarify, state regulations require a hospice chaplain to:

- Be ordained, commissioned or credentialed according to the practice of an organized religious group; AND,
- Have proof of completion of at least one CPE unit OR a minimum of a bachelor's degree with an emphasis in counseling or related subjects.

A chaplain who has been ordained, commissioned or credentialed AND has a minimum of a bachelor's degree with an emphasis in counseling or related subjects must receive additional training within 90 days of hire. That training must address common spiritual issues in death and dying, belief assessment skills, how to individualize care to patient beliefs, and varied spiritual practices or rituals. Proof of the training must be documented in the chaplain's file.

A chaplain who has been ordained, commissioned or credentialed AND has proof of completing at least one CPE unit does not require the additional training.



Alternate forms of this publication for persons with disabilities may be obtained by contacting the Missouri Department of Health and Senior Services' Bureau of Home Care and Rehabilitative Standards, P.O. Box 570, Jefferson City, MO, 65102-0570, 573-751-6336.

Hearing- and speech-impaired citizens can dial 711. AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER. Services provided on a nondiscriminatory basis.